Senate Bill 310

By: Senators Hawkins of the 49th, Murphy of the 27th, Goggans of the 7th, Williams of the 19th, Carter of the 1st and others

AS PASSED

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide for regulation and licensure of pharmacy benefits managers by the Commissioner of Insurance; to provide for definitions; to provide for license requirements and filing fees; to provide for requirements and procedures affecting pharmacy benefits managers; to require a surety bond; to provide that a pharmacy benefits manager shall not engage in the practice of medicine; to make certain audit requirements applicable to pharmacy benefits managers; to provide that a pharmacy benefits manager shall not have to be licensed as an administrator; to provide for regulation and licensure of multiple employer self-insured health plans by the Commissioner of Insurance; to change certain license requirements; to remove certain aggregate excess stop-loss and individual excess stop-loss coverage requirements; to change certain reporting requirements; to provide for a minimum loss ratio percentage and standards; to provide for application requirements; to provide for applicability of insurance laws; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new chapter to read as follows:

"CHAPTER 64

33-64-1.

As used in this chapter, the term:

(1) 'Business entity' means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(2) 'Commissioner' means the Commissioner of Insurance.

(3) 'Covered entity' means an employer, labor union, or other group of persons organized in this state that provides health coverage to covered individuals who are employed or reside in this state.

(4) 'Covered individual' means a member, participant, enrollee, contract holder, policy holder, or beneficiary of a covered entity who is provided health coverage by a covered entity.

(5) 'Health system' means a hospital or any other facility or entity owned, operated, or leased by a hospital and a long-term care home.

(6) 'Pharmacy benefits management' means the service provided to a health plan or covered entity, directly or through another entity, including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including, but not limited to, any of the following:

(A) Mail service pharmacy;

(B) Claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs;

(C) Clinical or other formulary or preferred drug list development or management;

(D) Negotiation or administration of rebates, discounts, payment differentials, or other incentives for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular prescription drugs;

(E) Patient compliance, therapeutic intervention, or generic substitution programs; and

(F) Disease management.

(7) 'Pharmacy benefits manager' means a person, business entity, or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. The term does not include services provided by pharmacies operating under a hospital pharmacy license. The term also does not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures.

33-64-2.

(a) No person, business entity, or other entity shall act as or hold itself out to be a pharmacy benefits manager in this state, other than an applicant licensed in this state for the kinds of business for which it is acting as a pharmacy benefits manager, unless such person, business entity, or other entity holds a license as a pharmacy benefits manager issued by the Commissioner pursuant to this chapter. The license shall be renewable on an annual basis. Failure to hold such license shall subject such person, business entity, or

other entity to the fines and other appropriate penalties as provided in Chapter 2 of this title.

(b) An application for a pharmacy benefits manager's license or an application for renewal of such license shall be accompanied by a filing fee of $500.00 for an initial license and $400.00 for renewal.

(c) A license shall be issued or renewed and shall not be suspended or revoked by the Commissioner unless the Commissioner finds that the applicant for or holder of the license:

(1) Has intentionally misrepresented or concealed any material fact in the application for the license;

(2) Has obtained or attempted to obtain the license by misrepresentation, concealment, or other fraud;

(3) Has committed fraud; or

(4) Has failed to obtain for initial licensure or retain for annual licensure renewal a net worth of at least $200,000.00.

(d) If the Commissioner moves to suspend, revoke, or nonrenew a license for a pharmacy benefits manager, the Commissioner shall provide notice of that action to the pharmacy benefits manager, and the pharmacy benefits manager may invoke the right to an administrative hearing in accordance with Chapter 2 of this title.

(e) No licensee whose license has been revoked as prescribed under this Code section shall be entitled to file another application for a license within five years from the effective date of the revocation or, if judicial review of such revocation is sought, within five years from the date of final court order or decree affirming the revocation. The application when filed may be refused by the Commissioner unless the applicant shows good cause why the revocation of its license shall not be deemed a bar to the issuance of a new license.

(f) Appeal from any order or decision of the Commissioner made pursuant to this chapter shall be taken as provided in Chapter 2 of this title.

(g)(1) The Commissioner shall have the authority to issue a probationary license to any applicant under this title.

(2) A probationary license may be issued for a period of not less than three months and not longer than 12 months and shall be subject to immediate revocation for cause at any time without a hearing.

(3) The Commissioner shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period in accordance with rules and regulations.

(h) A pharmacy benefits manager's license may not be sold or transferred to a nonaffiliated or otherwise unrelated party. A pharmacy benefits manager may not contract or subcontract any of its negotiated formulary services to any unlicensed nonaffiliated

business entity unless a special authorization is approved by the Commissioner prior to entering into a contracted or subcontracted arrangement.

(i) In addition to all other penalties provided for under this title, the Commissioner shall have the authority to assess a monetary penalty against any person, business entity, or other entity acting as a pharmacy benefits manager without a license of up to $1,000.00 for each transaction in violation of this chapter, unless such person, business entity, or other entity knew or reasonably should have known it was in violation of this chapter, in which case the monetary penalty provided for in this subsection may be increased to an amount of up to $5,000.00 for each and every act in violation.

(j) A licensed pharmacy benefits manager shall not market or administer any insurance product not approved in Georgia or that is issued by a nonadmitted insurer or unauthorized multiple employer self-insured health plan.

(k) In addition to all other penalties provided for under this title, the Commissioner shall have the authority to place any pharmacy benefits manager on probation for a period of time not to exceed one year for each and every act in violation of this chapter and may subject such pharmacy benefits manager to a monetary penalty of up to $1,000.00 for each and every act in violation of this chapter, unless the pharmacy benefits manager knew or reasonably should have known he or she was in violation of this chapter, in which case the monetary penalty provided for in this subsection may be increased to an amount of up to $5,000.00 for each and every act in violation.

(l) A pharmacy benefits manager operating as a line of business or affiliate of a health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society licensed in this state or of any affiliate of such health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society shall not be required to obtain a license pursuant to this chapter. Such health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society shall notify the Commissioner annually, in writing, on a form provided by the Commissioner, that it is affiliated with or operating as a line of business as a pharmacy benefits manager.

33-64-3.

(a) Every applicant for a pharmacy benefits manager's license shall file with the application and shall thereafter maintain in force a bond in the amount of $100,000.00 in favor of the Commissioner executed by a corporate surety insurer authorized to transact insurance in this state. The terms and type of the bond shall be established by rules and regulations.

(b) The bond shall remain in force until the surety is released from liability by the Commissioner or until the bond is canceled by the surety. Without prejudice to any liability accrued prior to cancellation, the surety may cancel the bond upon 30 days' advance notice, in writing, filed with the Commissioner.

(c) Every applicant for a pharmacy benefits manager's license shall obtain and shall thereafter maintain in force errors and omissions coverage or other appropriate liability insurance, written by an insurer authorized to transact insurance in this state, in an amount of at least $250,000.00.

(d) The coverage required in subsection (c) of this Code section shall remain in force for a term of at least one year and shall contain language that includes that the insurer may cancel the insurance upon 60 days' advance notice filed with the Commissioner. Other terms and conditions relating to the errors and omissions policy may be imposed on the applicant in accordance with rules and regulations.

(e) In the event a licensed pharmacy benefits manager fails to renew, surrenders, or otherwise terminates its license, it must retain both the bond and the errors and omissions coverage for a period of not less than one year after the licensee has failed to renew, surrendered, or otherwise terminated the license.

33-64-4.

No pharmacy benefits manager shall engage in the practice of medicine.

33-64-5.

Pharmacy benefits managers, whether licensed pursuant to this chapter or exempt from licensure pursuant to subsection (l) of Code Section 33-64-2, shall be subject to Code Section 26-4-118, 'The Pharmacy Audit Bill of Rights,' to the same extent and in the same manner as pharmacies.

33-64-6.

A pharmacy benefits manager licensed pursuant to this chapter shall not be required to obtain a license as an administrator pursuant to Article 2 of Chapter 23 of Title 33 to perform any function as a pharmacy benefits manager pursuant to this chapter.

33-64-7.

The Commissioner may not enlarge upon or extend the provisions of this chapter through any act, rule, or regulation.

SECTION 2.

Said title is further amended by revising Code Section 33-50-3, relating to the application for license for any multiple employer self-insured health plan, as follows:

"33-50-3.

(a) Application for a license ~~must~~ shall be made on forms prescribed by the Commissioner. ~~No multiple employer self-insured health plan may be licensed unless it has and maintains a minimum of 250 covered employees.~~

(b) Every multiple employer self-insured health plan shall pay to the Commissioner annual license fees, as established by rule or regulation of the Commissioner.

(c) Every multiple employer self-insured health plan shall pay to the Commissioner the premium taxes ~~required for insurance companies as set forth in Chapter 8 of this title~~ on the plan's net retained premium after deducting premium paid by the plan to its excess insurer and any other applicable deductions provided for in Chapter 8 of Title 33. The applicable premium tax rate shall be the applicable rates for insurance companies provided for in Chapter 8 of Title 33.

~~(d) The Commissioner shall establish, by rule or regulation, security deposits for multiple employer self-insured health plans.~~"

SECTION 3.

Said title is further amended by revising Code Section 33-50-5, relating to aggregate excess stop-loss coverage and individual excess stop-loss coverage, as follows:

"33-50-5.

~~A multiple employer self-insured health plan shall include aggregate excess stop-loss coverage and individual excess stop-loss coverage provided by an insurer licensed by the state. Aggregate excess stop-loss coverage shall include provisions to cover incurred, unpaid claim liability in the event of plan termination. The excess or stop-loss insurer shall bear the risk of coverage for any member of the pool that becomes insolvent with outstanding contributions due. In addition, the plan shall have a participating employer's fund in an amount at least equal to the point at which the excess or stop-loss insurer shall assume 100 percent of additional liability. A plan shall submit its proposed excess or stop-loss insurance contract to the Commissioner at least 30 days prior to the proposed plan's effective date and at least 30 days subsequent to any renewal date. The Commissioner shall review the contract to determine whether it meets the standards established by this chapter and respond within a 30 day period. Any excess or stop-loss insurance plan cannot be canceled without 90 days' notice to the insured and the Commissioner.~~

(a) No multiple employer self-insured health plan shall be licensed unless it shall possess and thereafter maintain a minimum surplus of at least $200,000.00.

(b) A multiple employer self-insured health plan shall be subject to and comply with the applicable regulatory action level risk-based capital requirements prescribed by Chapter 56 of this title.

(c) Every multiple employer self-insured health plan shall maintain a security deposit with the Commissioner. The amount of the deposit shall be $100,000.00 and shall be in the form of securities eligible for the investment of capital funds of domestic insurers. The deposit shall be administered in accordance with the provisions of Chapter 12 of this title.

(d) Every multiple employer self-insured health plan shall annually obtain an opinion from a qualified actuary as to the adequacy of its loss reserves. Such opinion shall be prepared and issued based on standards adopted from time to time by the Actuarial Standards Board and in accordance with instruction prescribed by the National Association of Insurance Commissioners.

(e) Every multiple employer self-insured health plan licensed pursuant to this chapter shall have an annual audit by an independent certified public accountant in accordance with Georgia Insurance Department Regulation 120-2-60 and instructions prescribed by the National Association of Insurance Commissioners.

(f) Every multiple employer self-insured health plan shall file financial statements with the Commissioner in accordance with the provisions of Georgia Insurance Department Regulation 120-2-18-.06.

(g) Every multiple employer self-insured health plan shall obtain and thereafter maintain aggregate excess stop-loss coverage and individual excess stop-loss coverage.

(1) Excess stop-loss coverage required by this Code section shall be issued by an insurer licensed by the state.

(2) The retention limits for both the aggregate excess stop-loss coverage and individual excess stop-loss coverage shall be determined annually by a qualified actuary based on sound actuarial principles.

(3) Any stop-loss contract maintained pursuant to this Code section shall contain a provision that the stop-loss insurer shall give the multiple employer self-insured health plan and the Commissioner a minimum of 180 days' notice of cancellation or nonrenewal.

(4) If the multiple employer self-insured health plan fails to obtain replacement coverage within 90 days after receipt of the notice of cancellation or nonrenewal, the trustees of the plan shall provide for the orderly liquidation of the multiple employer self-insured health plan.

(h) Each participating employer shall be jointly and severally liable for all legal obligations of the multiple employer self-insured health plans created on or after July 1, 2010.

(1) If the assets of the multiple employer self-insured health plan are at any time insufficient to enable the plan to discharge its legal liabilities and other obligations and to maintain the surplus required under this Code section, it shall forthwith make up the deficiency or levy an assessment upon its participating employers for the amount needed to make up the deficiency.

(2) If the multiple employer self-insured health plan fails to make up the deficiency or make the required assessment within 30 days after the Commissioner orders it to do so or if the deficiency is not fully made up within 60 days after the date on which any such assessment is made or within such longer period as may be specified by the Commissioner, the plan shall be deemed to be insolvent.

(3) If the liquidation of a multiple employer self-insured health plan is ordered, an assessment shall be levied upon its participating employers for such an amount as the Commissioner determines to be necessary to discharge all liabilities of the plan, including the reasonable costs of liquidation.

(i) A multiple employer self-insured health plan licensed before January 1, 2010, shall have until December 31, 2011, to comply with the provisions of this Code section."

SECTION 4.

Said title is further amended by revising Code Section 33-50-6, relating to requirements for holding of funds collected, as follows:

"33-50-6.

Funds collected from the participating employers under multiple employer self-insured health plans ~~must~~ shall be held in trust subject to the following requirements:

(1) A board of trustees elected by participating employers ~~must~~ shall serve as fund managers on behalf of participants. Trustees ~~must~~ shall be plan participants or be an employee or owner of a participating employer or an employee of a sponsoring association. No participating employer ~~may~~ shall be represented by more than one trustee. A minimum of three and a maximum of seven trustees may be elected. Trustees ~~may~~ shall not receive remuneration but they may be reimbursed for actual and reasonable expenses incurred in connection with duties as trustee;

(2) Trustees ~~must~~ shall be bonded in an amount not less than $150,000.00 from a licensed surety company or covered under a directors and officers liability policy issued to the multiple employer self-insured health plan;

(3) Investment of plan funds ~~is~~ shall be subject to the same restrictions which are applicable to insurers as provided in Chapter 11 of this title; and

(4)~~Trustees, on behalf of the plan, shall file an annual report with the Commissioner by March 1 showing the condition and affairs of the plan as of the preceding December 31. The report must be made on forms prescribed by the Commissioner. The report shall summarize the financial condition of the fund, itemize collections from participating employers, detail all fund expenditures, and provide any additional information which the Commissioner requires.~~ A multiple employer self-insured health plan shall maintain a minimum loss ratio of at least 70 percent. Compliance with such minimum loss ratio standard shall be evaluated annually by a multiple employer self-insured health plan. Failure to comply with minimum loss ratio standards shall result in a premium refund to participating employers.″

SECTION 5.

Said title is further amended by revising Code Section 33-50-7, relating to loss reserves for incurred losses and surplus account, as follows:

″33-50-7.

~~(a) A plan shall establish loss reserves for all incurred losses, both reported and unreported, for expenses and for unearned premiums in a manner and amount established by the Commissioner by rule or regulation.~~

~~(b) A plan also shall establish a surplus account equal to the greater of:~~

~~(1) Three times the average paid monthly premium during the plan's most recent fund year;~~

~~(2) For plans which do not yet have one fund year's experience, three times the estimated monthly premium; or~~

~~(3) One hundred thousand dollars.~~

Every application for benefits and every benefit plan issued by a multiple employer self-insured health plan shall contain in contrasting color, in not less than ten-point type, the following statements:

(1) The plan is a self-insured plan, and benefits are not guaranteed by a licensed insurer;

(2) The plan is not covered by the Georgia Life and Health Guaranty Association;

(3) This is a fully assessable benefit plan. In the event that the multiple employer self-insured health plan is unable to pay its obligations, participating employers shall be required to contribute on a joint and several basis the funds necessary to meet any unpaid obligations; and

(4) Certain other major protections offered to Georgia residents under the Georgia Insurance Code and Rules and Regulations, such as conversion rights and certain

mandated or required benefits, may not be available through the multiple employer self-insured plan.″

SECTION 6.

Said title is further amended by adding a new Code section to read as follows:

″33-50-14.

A multiple employer self-insured health plan, which covers lives in other states, may cover lives in this state only if the Commissioner deems the plan to be in compliance with the requirements of this chapter.″

SECTION 7.

Section 1 of this Act shall become effective on January 15, 2011. All other sections of this Act shall become effective on July 1, 2010.

SECTION 8.

All laws and parts of laws in conflict with this Act are repealed.